The President of the
Royal Medical &
Chirurgical Society
with the Author's
kind regards.

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Gynæcology in Relation to Surgery

by

Alfred Dorm

1892

INAUGURAL ADDRESS

ON

GYNÆCOLOGY IN RELATION TO SURGERY.

BY

ALBAN DORAN, F.R.C.S.,
PRESIDENT.

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Gentlemen,—Owing to the very nature of things, the polite observations which it is the duty of every newly elected President to make before the Society when he begins his Inaugural Address do not allow free scope for originality of treatment. I happen, however, thanks to your favour, to be unusually fortunate. In electing me the Society has given me a rare opportunity for beginning my address with an original remark. Though the twenty-first of your Presidents, I am the first surgeon to take the Chair, the first President selected from the ranks of those academically humble persons who hold no University degree. Therefore I must thank you with a gratitude which ought to be deeper than that which was felt on a similar occasion by any of that noble twenty who have preceded me. With me the Society has literally begun a new score ; I trust, therefore, that when my term of office has come to an end I shall not leave any old scores to be wiped out.

I feel, gentlemen, however, that in selecting me you are complimenting my art rather than myself. I shall therefore devote this address to Gynæcological Surgery, dwelling specially on its relation to this Society and to the principles of surgical art and science in general.

Gynæcology in the First Year of the Obstetrical Society of London.

I am sometimes asked, "What is the *good* of a society?" and usually reply that I presume that the questioner is a pessimist, and looks on such an institution as an illusion. But some persons hold the same view of love and glory. Experience shows, however, that these two abstractions have deeply influenced men (and women) in general, and it also shows that societies have deeply influenced their members in particular. The influence of the Obstetrical Society of London on gynæcology has been great, as I will now remind you, and has extended beyond its Fellows.

From the first this Society was understood to devote itself to the advancement of the knowledge of Obstetrics *and* the Diseases of Women and Children. So said Dr. Rigby when he took the chair at the inaugural meeting of the Society, held at the Freemasons' Tavern, December 16th, 1858. He further added by the way, "The new Society would be eminently useful to general practitioners, most of whom have daily brought before their notice facts which the Society might be the means of registering." Dr. Rigby referred to midwifery, but the same observation applies to gynæcology, and the practitioner enjoys more advantages now than in 1859. The resources of science are more accessible to him, his professional education is, as a rule, sounder; hence we are justified in calling on him for the invaluable aid which he can afford us in the observation of acute and chronic, but more especially chronic, disease of the female genito-urinary tract. After-histories, so important to all who undertake surgical operations, come within his province; in hospital and special practice cases are too easily lost sight of. Dr. Rigby, as well as Dr. Tyler Smith, who seconded him, joined diseases of children with those of women. By "children" sucklings and

female children are understood, and I may mention the recent researches of Dr. Robinson to remind you what excellent work may be done in this field. Dr. Routh, at the same Inaugural Address, distinctly turned attention to the consideration of children's diseases. "How many lives of young and interesting children," he said, "were daily sacrificed by prescribing chemists and druggists! By pointing out the difficulties in the treatment of children's diseases this source of evil might be removed." Dr. Routh's advice is still needed. Now observe that as I wander through the first pages of our archives I soon get off the very narrow track of gynæcology. Sir William Fergusson spoke at this very meeting, but entirely on the elevation of obstetrics. The greatest British surgeon of his day said not a word on operations for the relief of women's diseases; yet Sir Spencer Wells, who had already started in his career as our ovariotomist, was actually present at the meeting. Nor when the Society was at length launched did Dr. Rigby dwell on gynæcology in his address delivered at its first meeting, on January 5th, 1859. His theme was obstetric practice, yet he uttered a prophecy which applies as much to gynæcology in relation to our Society as to obstetrics, and we have verified it in respect to both.

"A time will come, I feel assured, when the Obstetrical Society of London, with the prodigious advantages which are afforded it by our enormous population, and by the large and united body of its intelligent members, will possess treasures of knowledge far exceeding those of any joint-stock bank of science of the present day, and which will place it on a more enduring basis, and enable it to pay richer and more permanent dividends of science than any of those similar institutions of our monied brethren. We shall have a numerous list of fact-collectors and depositors, not only from every county of the United Kingdom, but also from our foreign members, and still more from the many correspondents in those

extensive colonies over which the sun never sets, all contributing vast funds of scientific facts and priceless knowledge, gleaned from varieties of the human race living under every modification of climate, habits, and grades of civilisation; and furnishing us with such an amount of accumulated science as will raise this Society to the loftiest pinnacle of dignity and importance."

This somewhat florid prediction of Dr. Rigby's has come true. He little knew—which is a form of speech signifying that he did not know at all—how near was the advent of ovariotomy as an established operation. I need not criticise the "minor gynæcology" and "gynæcological therapeutics" of 1859; we have improved, as our successors will improve on us. Nor need I remind you of the earlier triumphs of McDowell, Jeaffreson of Framlingham, and Clay.

It is the gynæcological work of the Obstetrical Society with which we have at present to do. Charles Clay himself could not justly complain that we disregarded his early labours. Putting aside Graily Hewitt's communication on a special trocar for the diagnosis of ovarian cystic disease—which, by the way, was used, we are informed, in a case "under the care of Mr. Spencer Wells,"—the first paper seriously treating of ovariotomy is by Clay, and stands as the twenty-third paper in our first volume. It is true that the main subject of Clay's communication is not treated in a satisfactory manner by its author, who declares that in the middle of May, 1859, ten days after a patient's delivery, he "drew off nine pounds of a greasy chocolate-coloured fluid having a very faint urinous smell" on passing the catheter, the patient having been long under his care for an ovarian cyst. Then Clay tells us that she continued to improve "up to this date," July 6th, not two months afterwards. Our predecessors were, after all, sometimes in a hurry, as we often are now. Still Clay proceeds to relate how he had successfully performed ovariotomy two months after delivery, the patient bearing

children after her recovery—a brilliant case for those days and an ornament to our earlier pages.

In the third volume, however, gynæcology, so neglected in the two inaugural orations, already comes to the front. It is no longer in the background, but takes up a respectable proportion of the text; not only do we read of fibrous polypi, hernia of the ovary, &c., not only did Dr. Robert Barnes point his finger to pathological conditions now so familiar to us, in his "case of peritonitis caused by escape of pus or putrilage (*sic*) from the Fallopian tube into the abdominal cavity, following on abortion artificially induced," but Spencer Wells, Tyler Smith, and others now began to discuss their progress in ovariotomy well in earnest. From then till the present moment our Society has ever been distinguished for its gynæcological work.

The Present Position of Gynæcological Science.

Without doubt, gynæcology is an established speciality. Its foundations are now firm. The patient study of the diseases of women involves a very sound clinical training. That table in front of me has borne witness what great advances have been made in the pathology of the female genital tract, and long may that table remain pathological! Our interest in pathology continues unabated. You all remember the Homeric contest between Mr. Bland Sutton and myself about tubal clots and chorionic villi. I must say that obstetric pathology has been slower in development. We are all interested in that strange phenomenon, the awful appearance of deciduoma malignum on the medical stage. Dr. Eden, a leading authority on the histology of the products of conception, has warned us that specialists working in this field must begin with a sound practical knowledge of general histology and pathology lest they should mistake general for special conditions, sarcoma for syncytium, whatever that precisely

means. We constantly need a general pathologist to check our theories in these matters, and we had such a one who did us that service on a memorable occasion. But, alas! Professor Kanthack is no longer amongst us.

Gynæcological Surgery, its Triumphs and its Abuses.

The proudest boast of general gynæcology, however, is that general surgery is perhaps more indebted to it than it is indebted to general surgery. Pride is dangerous, and I will presently note how, just as some persons are apt to believe that law is identical with justice, so gynæcologists are in danger of thinking that operating necessarily means surgery. Yet ours is a proud boast, though our work is too well known here to require any long summary. Ovariotomy is ours in history. It revolutionised abdominal surgery. It opened up unknown fields alike to the general surgeon and the obstetrician. Witness nephrectomy and cholecystotomy. Remember what Cæsarean section and extra-uterine pregnancy once meant, and what they mean now. Yet let us not be carried away by our subject; this good work was not done by boasting. I will "fall somewhat into a slower method," like Richard, Duke of Gloucester, and devote the remainder of this address to gynæcological operations; endeavouring to distinguish those which are undoubtedly good surgery, those which are sometimes good surgery, and lastly those which seem more or less questionable.

Uterine therapeutics and minor gynæcology.—I need not dwell on "uterine therapeutics" and "minor gynæcology;" many abuses, we know, have been associated with these expressions, but the same can be said of the terms "medicine" and "surgery." They largely correspond to dressing and bandaging as taught by every good house surgeon. When parts have to be explored, they must be exposed as much as their anatomy permits, consistently with the safety and sensitiveness of the patient. When douching is needed the best form of douche should

be used, and it will be well if douches be yet improved upon by skilful mechanicians. Artificial support is certainly needed in most cases of bad displacement. The laws of scientific surgery forbid us to say "Leave such cases alone, and tell the patients that the symptoms are all imaginary;" nor, on the other hand, will it urge us to use the knife and the suture-thread for all flexions and prolapses. Thus the middle course, artificial support, is often indicated. There will always, I suspect, be some kind of pessary in use, though there are still great objections to every form now in vogue, and therefore great room for improvement.

We must never fail to remember and to teach that, as in the case of the abscess-knife and the catheter, "minor" proceedings with the curette, the sound, and other special instruments are liable to kill if clumsily performed, and under many circumstances are not free from danger even when undertaken by men of skill and experience. It is especially in uterine therapeutics and "minor" gynæcology that certain methods in fashion are apt to be unduly relied upon. Once caustics were freely used in chronic metritis; the curette is now held by many to be the right instrument to employ in that disease. Delbet, however, an accurate observer, now declares that he has gone back to chloride of zinc as an agent superior to the curette and less dangerous.

Let us now, however, accompany gynæcology in its higher flights, and consider the present position of gynæcological science.

Plastic surgery.—The plastic surgery of the female organs was already understood when the Society was founded. As early as the beginning of Her Majesty's reign Fleming and Marshall Hall reported their new method of performing anterior colpotomy. In 1859 Marion Sims was a well-known man, famous for his skill in the repair of vesico-vaginal fistula; it is our progress in obstetrics that we have to thank for having such few opportunities of performing that operation now-a-days.

Several well-known Obstetric Fellows practised repair of the ruptured perinæum in 1859. This operation has been much simplified, and there has been great advance in surgical procedures of this class. I have been referring to the plastic surgery of the vulvar and vaginal region only. As for that branch, as I may term it, which is more or less intra-peritoneal, it includes many remarkable operations of recent invention, but many of us must doubt whether they indicate "advance" or "progress," and whether they mean surgery as well as operating. I intend to dwell presently on some evident abuses in this direction. I admit in my own experience that abdominal hysteropexy is in some cases, and with certain precautions, a good surgical procedure, but I know that it may be grossly abused.

Vagino-abdominal surgery.—The removal of the uterus through the vagina comes under surgical novelties. In cancer, when not too advanced, this operation seems to be good surgery, measured by the cancer practice of the general surgeon of the day. The mortality is low, at least. I find that Dr. Halliday Croom, in his inaugural address recently delivered before the Obstetrical Society of Edinburgh, is disposed "to think that the surgical method of dealing with uterine cancer has done little either to ameliorate suffering or to prolong life, and that once a uterine cancer is recognised palliative local measures and a happy euthanasia through morphia are the best solutions of the difficulty." This statement was repeated by Dr. Halliday Croom, on the strength of personal experience, at the meeting of the Edinburgh Obstetrical Society held just three weeks ago. Out of 200 cases of cancer only fourteen were operated upon, as the cancer was in an early stage and strictly limited. Yet in all the disease returned, and he believed that the women's lives had been shortened, and that they suffered more than the patients on whom no operation was performed.* I do not think that our experience of hysterec-

* See 'Edinburgh Med. Journ.,' March, 1899.

tomy for cancer is quite so gloomy, especially as regards the patient's sufferings after the operation. Most of us find that the local condition is ameliorated. We must not, however, forget that the going through an operation is, to say the least, a disagreeable experience, even for a patient with a trifling complaint. Hence, though much has been said here about uterine cancer and operation, perhaps we might advantageously gauge the merits of surgical interference once more. The hopeless cases urgently require the assistance of our art for palliative measures. I may, therefore, mention the recent experience of Westermark of Stockholm, for which he claims satisfactory results. He scrapes clean the cancerous area in the cervix, and fits into the chasm a small Leiter's coil, through which hot water is passed for a prolonged period, on the principle of the constant heat system so valuable in the treatment of syphilitic phagedæna.

Ovariotomy.—We all know how the exertions of Clay, Spencer Wells, and Keith not only established this operation, but likewise started the wonderful recent developments of abdominal surgery. The operation afforded the surgeon invaluable experience in the cleansing of the peritoneum, its effective drainage (a very grave question, not yet settled), and the flushing of the peritoneal cavity, for which we were originally indebted to Mr. Lawson Tait, though since he introduced this valuable resource its utility has been found even greater than he ever suspected it to be. Shortly after flushing became generalised it was noticed that it acted like a transfusion, as well as serving as a hæmostatic, a remover of noxious fluids and solids, and a counteractor of shock. Indeed, transfusion and flushing have been inextricably mixed up since the actual danger of blood and the value of water artificially introduced into the circulation have been demonstrated by experience, and since other methods besides intra-venous transfusion have proved effective. In lving this transfusion question, obstetrics, gynæcology' nd our Society have played a conspicuous part. To

the first volume of our 'Transactions' Dr. Charles Waller contributed a monograph "On Transfusion of Blood," with drawings of the instruments which he employed for the purpose, whilst in our thirty-fifth (1893) is to be found Dr. Horrocks's valuable contribution on "Intra-venous Injection of Saline Solution in Cases of Severe Hæmorrhage." Once more, with ovariotomy and its developments are closely blended antiseptic and aseptic surgery. I need not dwell further on the operation, it is so familiar to you. It may be a simple proceeding, but even then ligatures may yield, or tetanus or some more frequent complication may cause death. The youngest and the most experienced must alike remember the words of a French operator, "*Faire une ovariotomie c'est marcher vers l'inconnu.*"

Operations for diseases of appendages due to inflammation.—We now come to a class of cases where a skilful and successful operation may be decidedly bad surgery, or else questionable surgery, or else very good surgery. The remarks which I am about to make on this subject were suggested by the instructive "Discussion on the Surgery of Pelvic Inflammation," introduced by my predecessor, Dr. Cullingworth, in the section of obstetrics and gynæcology at the Edinburgh meeting of the British Medical Association, last August.*

Inflammation of the parametritis or cellulitis type usually subsides under appropriate medication. The formation of abscess, its position, and the proper surgical treatment have long been known. It is quite wrong to hurry on surgical interference in ordinary puerperal cellulitis. Two authorities, very different in their opinions and practice, are, I am glad to find, practically in accord on this point. Sir William Priestley says, in a tone of just censure, "I have known the uterine appendages removed for matting together of parts by pelvic cellulitis and peritonitis after delivery, because the patient was too impatient to wait for the slow recovery which would have taken place

* Published in the 'British Medical Journal,' vol. ii, p. 461.

in due course." On the other hand, Doyen of Rheims simply states that in extra-peritoneal pelvic suppuration "it is well to make an immediate opening above the crural arch" when the abscess points in the iliac fossa; whilst he teaches that "purulent collections low down in the broad ligament may be advantageously opened by a *lateral colpotomy*"—that sounds formidable, but let us read on—"by plunging into the inflamed ligament a long forceps, and emptying the abscesses that lie low down close to the uterine artery. I have done that operation several times with success, and it is a very simple one for a surgeon who is accustomed to do vaginal hysterectomy." But M. Doyen simply means that a pelvic parametric abscess is best opened after what we call Hilton's method. No mutilation is practised, and the pus can escape, which is the aim of the operation. Even old neglected cases with sinuses hardly call for special operative treatment. We all know how overworked and sickly women among the poor come to out-patient departments with the uterus fixed in firm deposit, yet after a few weeks that organ is often found quite moveable.

Our principles of treatment should be at first much the same in inflammation of the tube and ovary. Many ladies and workwomen recover perfectly in spite of their carelessness or inability to get proper rest. I find that puerperal and gonorrhœal disease of the appendages may alike disappear almost spontaneously, and regret to read of opinions implying that they cannot do so. A tender, moveable ovary should never be removed forthwith; a tender but recent fixed mass in the pelvis should never be opened or exposed by the knife until after the effects of medical treatment have been carefully watched. The case is quite otherwise when inflammatory disease is chronic with a reliable history. Exploratory incision is often needed. The surgeon should never hesitate to leave the ovaries and tubes if they be found not so much diseased as to demand removal. I have seen perfect

comfort and complete restoration of function follow in cases where I have liberated the appendages from old adhesions which bound them firmly down in the pelvis. The operator is wrong who decides to remove the liberated appendages because "it looks so bad" to do an operation and take nothing away. I am glad to see that Landau, in his tables of cases of vaginal cœliotomy, which I will show presently to be unsatisfactory in one respect, demonstrates at least that he does not always cut something away. Thus in a case of "perimetritis and right peri-oöphoritis," and in another specified as "chronic pelvic peritonitis," the tables state that "separation of adhesions" was all the operating done besides the incision through the vagina.

There is yet another vicious principle which teaches that when the appendages are removed on one side they must be removed on the other. I have frequently amputated a suppurating tube and ovary, leaving those on the opposite side because they were healthy, or only required to be delivered from the bondage of adhesions. The patients were not only restored to health, but in several instances bore children within a year or two of the operation. I find once more that Landau does not sacrifice both appendages in his vaginal cœliotomies; I know that the operation in question is not recommended by him for the extirpation of inflamed appendages, but at present we have only to consider the fact that this distinguished German operator places many unilateral operations in his tables of vaginal cœliotomy.

Bad cases of bilateral pyosalpinx seem to demand removal of both tubes. The operation is always serious, and convalescence is but rarely quite smooth. The relative merits of vaginal and abdominal operation are still under debate. The great enemy of success in these cases is the stump, so often unhealthy. I usually touch it with tincture of iodine, and sometimes sew the serous membrane over the raw surface. Unfortunately the ligature may be infected, as the connective tissue of the

broad ligament through which it passes may contain septic foci. But removal of the uterus with the suppurating appendages always seems to me to be a grave step not absolutely justified. Its advocates note that the after-histories of cases of simple oöphorectomy are unsatisfactory, but do not seem to furnish us with convincing after-histories of cases where the uterus is also sacrificed. Even Doyen, a great expert in hysterectomy, states, "Is it rational to practise ablation of the uterus, by laparotomy, in any case of bilateral suppuration of the annexa? I have never thought that it applied to all suppurating salpingitis, but that it was an exceptional operation to be used in certain well-defined cases. When the uterus is healthy and not painful, and when its ablation in women much reduced in strength may lead to an aggravation of their state, it should be left in its place. . . . . In certain cases of salpingitis the uterus was found useful in closing the pelvic cavity by attaching it by a continuous suture of fine silk to the mesenteric folds adjoining." I will not discuss the foreign theory that in vaginal oöphorectomy, at least, the uterus should be sacrificed.

It is the duty of the surgeon to make sure that his patient does not merely recover from the operation. I have already referred to Landau's vaginal cœliotomies. He admits that "in the hands of an unscrupulous operator it may become a terrible scourge." He is right to warn us, but in his own tables over twenty cases were performed within eight months of their publication, eight within six weeks, nor is there a single after-history; yet the greater number of the operations were for salpingitis or oöphoritis. Another undoubtedly able foreign operator registers 424 "cures" out of 432 extirpations of the uterus and appendages through the vagina, and 95 "cures" out of 98 extirpations of the uterus and appendages through an abdominal incision, all for suppuration. "After an experience," says this authority, "of several hundred cases, after very strict study of the results of

operation, I find that the risk of operating is not greater by one way than by the other." This is a very definite statement, but why does not this experienced operator let us know his definition of the word "cure"? Out of a total of 519 recoveries, what a valuable series of two years' histories we hope to hear of! Do the patients suffer from an artificial menopause? Do the pieces of tubal tissue inseparable (not rarely the case) from the serous coat of large and small intestine *never* give trouble? The operator's "very strict study of the results of operation," which, as we have seen, refers to "the risk of operating" should be complemented by what is more important, a yet more "strict study" of the after-effects of operation. The British gynæcologist would also like enlightenment about another matter; what are the local causes of pelvic inflammation so severe that one operator in a relatively small town finds it necessary to remove appendages and uterus in over 500 cases, for the cure of that disease? In London all the immediate and predisposing causes of inflammatory disease of the tube and ovary are present in force—neglected childbed, neglected abortion, gonorrhœal infection, enteric fever, and carelessness or exposure to prejudicial influences during menstruation. Yet few, if any, of us find it necessary to proceed so frequently to such an extreme measure as total extirpation of the uterus and appendages.

In this country we believe that if we remove the appendages with or without the uterus in every average chronic case of tubo-ovarian inflammation, we should undoubtedly sacrifice many appendages that would have recovered under less radical treatment. Nevertheless, the majority of these operations would most probably be followed by satisfactory after-histories, for the unsatisfactory after-results in bad cases are largely due to the fact that the operation wounds and the ligatures pass through diseased tissues. In average cases the same tissues are usually sound, and bear manipulating, cutting, and tying. Hence even good after-histories do not by

any means prove that the operation was justifiable. On the other hand, we must not always expect complete immunity from discomfort after operation on a severe case, where the removal of a dilated suppurating tube is clearly sound surgery.

Removal of ovaries for neuroses unjustifiable.—It is satisfactory to find that an operator of such high reputation as Dr. Howard Kelly admits in his standard work, which treats of very operative gynæcology, that his attitude with regard to removal of the ovaries for dysmenorrhœa will be seen by the fact that in a recent series of 500 abdominal sections at the Johns Hopkins Hospital only four cases were operated on for this reason, and in three of these the relief was not what was looked for. He observes—

"The patient herself can never be the right judge as to the necessity of removing the ovaries. I have seen young women who suffered so severely at the menstrual periods that they were importunate in their demands for radical relief and were willing to submit to any operation; removal of the ovaries suppressed the function, but in place of the pain a train of nervous symptoms appeared, along with the realisation that they were unsexed and could not morally assume the relationship of marriage with the hope of maternity, and profound mental depression supervened."

Again, Howard Kelly remarks—

"The various neuroses, such as menstrual epilepsy, hysteria and hystero-epilepsy, and insanity, do not of themselves justify the removal of the uterine tubes and the ovaries. It has long been fondly held by gynæcologists that in major epilepsy of a distinctly menstrual type—that is to say, occurring always during, just before, or immediately after the menstrual period—the expectation of a radical cure from the suppression of the periodical function was fully justified, but the facts of the case do not so far bear out this assumption."

Howard Kelly quotes Dr. Weir Mitchell, who says, "In

no case seen by me had ablation of ovaries and termination of menstruation cured an epilepsy. I have never sanctioned such an operation where the appendages were sound. I have agreed thrice to these operations in epilepsy with such pelvic disease as of itself would justify oöphorectomy. In all three, after some delay, the fits returned, and were in no way permanently aided."

Dr. Mitchell then adds a most instructive case:—

"I recall as an illustration a case in which there were epileptic attacks of great severity only at the menstrual epoch. The ovaries were apparently sound, but, as two physicians and a surgeon were against me, my opinion was not regarded and ovariotomy was performed. The attacks, which had been daily, stopped for seven weeks after the operation, *and the case was hastily spoken of as a great triumph.* The patient, however, then became worse and a permanent loss of mind resulted. . . . . *The ease of operation, the freedom from mortality, makes that seem of little moment which should in every case receive the gravest consideration.* . . . . In all my life I have met with but four reflex epilepsies; none were from uterine or ovarian or tubal disease."

Lastly Angelucci and Pieraccini have collected reports of 109 cases, in different countries, where removal of the internal organs of generation was undertaken for the cure of hysteria, insanity, and other nervous disorders. Only seventeen were, according to the operators' own testimony, influenced beneficially, and in twenty cases where the operation was undertaken for hysteria, insanity developed afterwards, whilst twenty insane and hysterical patients were distinctly the worse for surgery.

Fibroids and hysterectomy.—The opinions of Fellows of the Obstetrical Society on this subject are well known. As for the limitations of the operation, that is a matter on which we are by no means agreed. Putting aside those few who object to the operation altogether save where the tumour is so large, or the prejudicial effects so extremely marked, that the risks of hysterectomy are

excessive, we may agree that under certain conditions hysterectomy for uterine fibroid is right. These conditions are well known. The tumour may not destroy life, whilst removal of the uterus may prove fatal, but patients value other things besides life, and the operation may involve more risk if delayed till the sufferer has passed through a year or two more misery or constant discomfort. I think, gentlemen, our rule should be: when in doubt, watch. I have mounted guard over a very large number of fibroids for years, the patients remaining in good health with little variation in the size of their tumours. Some cases, however, have been the worse for waiting. What we all want to know is where the border-line should be drawn. We must remove very rapidly growing tumours, particularly when they increase in the direction of the pelvis. Fibroids of the broad ligament should always be extirpated when diagnosed; that is to say, a hard, more or less fixed mass, with the cervix and body of the uterus distinct, yet closely connected with it, demands an exploratory operation. Error in diagnosis nearly always means that the tumour is a fibroma of the ovary, which certainly requires removal. Delay, when there is no trustworthy clinical evidence that the growth is stationary, exposes the patient to grave pressure effects, and the danger of an operation which is never easy is much increased when the tumour is large. I myself would also place on the operation side all cases of uterine fibroid where there is steady growth with steady softening of the tumour, whether in youth or towards the menopause. Tumours of this class, often unassociated with bleeding, are very dangerous to remove when large. The vessels are dilated, the uterus and cervix thick, and the parametrium œdematous and intolerant of much handling, tying, and sewing. Hence I think that such a case must not be watched too long.

I wish it to understood that we must not think too much about the risk of malignant degeneration. Martin, of Berlin, an advocate of hysterectomy in what may be

termed average cases, admits that he has only observed sarcomatous changes in six out of 205 fibroids. I have only observed one genuine case in the entire practice of the Samaritan Hospital since 1877. Olshausen speaks just as definitely, "amidst hundreds of myomas, often not a single case of the kind is met with."

However, I must return to the rectification of the frontier. I would not place on the operation side cases where the patient urges removal of a fibroid because it worries her. Howard Kelly says, "I have, however, operated two or three times solely on account of the distressed mental condition of the patient, induced by the knowledge that there was a tumour which she could feel in the abdomen; until the operation was done it was impossible to allay the fears or to persuade the patient to think of anything else but the tumour, and no reasoning had any effect."

This statement is open to criticism, though the frank admission that "*I* have, however, operated" shows that the author is taking full responsibility whilst not justifying operation under such circumstances as a general practice. The size of the tumour in each of these "two or three" cases should have been given; indeed, as the author furnishes us with no clinical reports the whole statement may mislead many of his readers. We can give wholesome advice to such a patient if the tumour be small and stationary. We cannot teach her pathology, but we can tell her a pathological truth of direct concern to herself; we can inform her that a fibroid is not a cancer, and if she talks about a friend who recovered from ovariotomy, we can assure her that ovarian tumours are always dangerous to life and are best removed when diagnosed, whilst uterine fibroids seldom kill and are rarely so bad as not to allow of watching.

Speculative operating on uterine fibroids must, I think, be condemned entirely. Under this head I include the removal of a fairly large, hard fibroid in a woman over forty, immediately on diagnosis, without watching for

awhile, though the tumour causes no serious symptoms. Few now advise removal of a small myoma because it might grow big. We know the views of Fellows of the Society, so I need not dwell on them. All of us are aware that these tumours do not, as a rule, grow dangerous.

In other quarters we find that the same opinion prevails. Kelly, whom it is fair to quote under the circumstances, states, "*I feel it my duty to utter an urgent warning against accepting the simple fact of the presence of a tumour as a sufficient indication for operation.*"

Olshausen, a great authority, is very clear in his verdict against speculative operations. "When we ask sincerely if patients with fibroids frequently perish owing to the fibroid, whether directly or indirectly, the reply must be absolutely No!" He even admits that the anæmia from the hæmorrhage is seldom fatal. In this respect, Olshausen, who has done much to perfect retro-peritoneal abdominal hysterectomy, implies that he is even more conservative than Sir William Priestley, who in his famous address "On Over-operating in Gynæcology," delivered at the London Meeting of the British Medical Association, remarked, "I have heard it affirmed that a uterine fibroid never killed a woman. This may in a sense be true, but nevertheless I have seen poor women so reduced by hæmorrhage or so suffering in other ways from them, that in their cases I should look with much less disfavour on any surgical interference which promised relief with even comparative safety."

The question is, however, I trust, settled in this Society, though there appears to be a criminal mania for operating in certain foreign climes.

Uterine displacements and surgery.—I fear that there is much abuse of operating in respect to uterine displacements. In certain cases the aid of surgery is certainly demanded. The subject is highly complicated, and not suited for brief review. We cannot soundly judge operations without first knowing the pathology of flexions and

versions, which does not appear to me to be by any means settled.

A long series of operations has been devised to pull the uterus up into its right place or to support it from below. On these I cannot dwell, but we must not be hasty in blaming our professional kindred simply because they have devised so many methods. Large text-books now current describe many operations of very different nature and principles performed for the remedy of the same kind of displacement by different operators. This fact clearly signifies that the disease is obstinate and dependent on conditions not always easy to counteract, that failure is therefore common and that gynæcologists are sincerely zealous for improvement. Unfortunately too much reliance has been placed on the knife and the suture-needle, and too often is it assumed that it is an operation, whatever that operation may be, that will ultimately cure the patient, granting that she takes care of herself. To feel sure of cure, however, we must be very patient, nor must we neglect to search for any ill results due to the operation. For this purpose only long after-histories are of the least avail. Some foreign writers seem to act against all these principles, especially the last. One professor of high authority recently published statistical tables of 359 vagino-fixations of the uterus. Six cases ended fatally. Over sixty were performed within eight months of the publication of the tables, nine within six weeks. After-histories are included, but some are only a month old. It is impossible to judge of the value of an operation of this kind on such evidence. Again, in a large majority of the series something was done to the tubes and ovaries, disease of the appendages being present. All this extra operating might have been quite justifiable; indeed operation was undertaken partly on account of tubal and ovarian disease faithfully noted in the tables, but as the summary of the tables reads "Vaginal fixation of the uterus *on account of retroflexion*," these remarkable records will certainly

incite many to undertake this particular operation for that particular purpose. The same author adds tables of six cases of vesico-fixation of the uterus for retroflexion. The professor very rightly admits that one case died a few days after discharge from hospital, where they had kept her for a month, from old heart disease. Another European operator of repute treats prolapse in elderly subjects by opening the abdomen and amputating the uterus as in retro-peritoneal hysterectomy for fibroids, lastly sewing the stumps of the broad ligament on to the peritoneal flaps already sewn over the stump of the cervix. I said lastly, but I must add that the proceedings terminate by a perineorrhaphy if the perineum be thin. One critic states that this operation is too recent and the number of cases still too limited to allow of fair comparison with allied methods. Those who wish to study the present attitude of operators should consult the lucid Greig-Smith like epitomes of operations still in vogue for the cure of displacements in Henri Delagénière's 'Chirurgie de l'Utérus.' The very table of contents looks formidable, bristling with proper names or terms in the Franco-Latin-Greek dialect applied to these surgical novelties. In their original treatises, the authorities which M. Delagénière quotes, seem to agree in omitting certain considerations such as my friend Dr. Herman takes care to impress on his readers. Thus, in respect to hysterectomy for prolapse, Dr. Herman concludes, as I will conclude these remarks on operations for displacement: "The descent of the pelvic floor is the essential condition, and that remains after the uterus has been removed. The vagina descends as before, only that at the bottom of it there is a scar instead of the os uteri."

Time forbids me to dwell on other important matters associated with the surgery of diseases of women, such as that remarkable subject extra-uterine gestation, which is like a polyhedron in its multiform aspects, pathological, clinical, gynæcological, obstetrical, and surgical, all of importance and all requiring much more elucidation.

Surgery has already triumphed here, but operation late in pregnancy remains fraught with peril, however able be the operator.

Gynæcological surgery, I may say in conclusion, has done great services to womankind, though, as in every other branch of surgery, whilst much is good and well established much remains uncertain. We must not be over eager to blame others who seem to us to do too much or to leave undone that which we think ought to be done, for we all lack sound knowledge such as alone can make us sure as to the duty of interference and non-interference. In this address I have avowedly dwelt on surgery, implying at the same time that surgical proceedings are only justified when clinical research has proved that there is something which ought to be removed or rectified by an operation. In this sense the surgery of ovarian tumours is soundly established; would we could say the same of most other diseases to which I have referred! Surgery must respectfully follow clinical exploration, otherwise not only the surgeon's knife but his powers of diagnosis also will be blunted by too many exploratory incisions. Patient clinical research is the sheet-anchor of the gynæcological surgeon.